Connecting Canada's Health Data—Canadian Institute for Health Information Annual Report, 2009–2010

April 2010

Canadian Institute for Health Information

Institut canadien d'information sur la santé

Who We Are

Established in 1994, CIHI is an independent, not-for-profit corporation that provides essential information on Canada's health system and the health of Canadians. Funded by federal, provincial and territorial governments, we are guided by a Board of Directors made up of health leaders across the country.

Our Vision

To help improve Canada's health system and the well-being of Canadians by being a leading source of unbiased, credible and comparable information that will enable health leaders to make better-informed decisions.

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Introduction

In a country as large as Canada, with so many jurisdictions responsible for their part of the health care system, it's not always easy to see the big picture and understand how each part connects or compares to the other. Each day in small remote health regions and large urban teaching hospitals, data is pulled from every part of this vast and complex system.

We know that data is relied on to improve the quality of care, plan services, measure performance, build business cases and even share experiences and apply lessons that have been learned. Together, these activities form a chain, linking data with decision-making and knowledge.

That's where we at CIHI fit in—helping to connect data from across the country to paint a comprehensive picture of our health care system. This allows our health partners to better understand what is working well and where improvements can be made, for the benefit of all Canadians and what they treasure most: their own health and the health of their families.

Message From the President and CEO

At CIHI, we know there is strength in numbers. Data leads to information and it is brimming with potential. We know there is even more power to be harnessed when we bring data together.

Although every health region in the country gathers data, it is because of the care and attention that goes into ensuring the data is collected consistently on a national level that comparisons among provinces, regions and hospitals can be made. This pan-Canadian perspective is critical to steering our health system, as it allows our stakeholders to share best practices and know where to focus their energies and attention.

For data to lead to action, there need to be comparators, benchmarks and, if possible, evidence-based standards to place the data in context and make it meaningful. This is what CIHI brings to the table. We set high standards for data collection, and we conduct regular and rigorous reviews of our work. This is critical to meet our mandate of providing timely, accurate and comparable information to inform health policies, support the delivery of health services and raise awareness among Canadians about the factors that contribute to good health.

We also set high standards for ourselves. We introduced new performance measures and targets this past year to gauge our progress against specific priority initiatives. This is making us even more accountable. As you'll read in this report, we were very successful in realizing the targets we set out to achieve. We increased the adoption and implementation of key reporting systems. We responded to our stakeholders' emerging issues by developing timely analytical products related to H1N1 and medical isotopes. We started a pilot of comparable pan-Canadian facility-level reports on hospital performance, including measures for clinical outcomes and financial health.

It's important to know how our stakeholders feel about the work we're doing, which is why we conducted a large-scale client satisfaction survey this year. Although the overall results were very positive, we recognized the need to get closer to our customers and take our products and services to the next level. We've made much progress over the past year. We laid the groundwork for several key initiatives to be launched next year, including a comprehensive new education strategy and a new website. We've also begun work on a new corporate-wide customer strategy that will align all of our initiatives.

To remain a trusted custodian of quality pan-Canadian health data, we have to make sure we're getting data to those who need it as quickly as possible. The health care system runs 24 hours a day, 365 days a year. It has no downtime. Part of our job is to ensure the information needed to help improve it follows suit. As always, we remain committed to connecting Canada's health data and providing value-added products and services for our provincial, territorial and federal stakeholders.

John Wright

Message From the Chair of the Board

In the wake of last year's recession, most governments across Canada are now facing deficits and are tightening their belts as a result. Health care, which represents 40% of provincial public program expenditure, has become a target for spending controls and efficiencies as governments look for ways to reduce their costs.

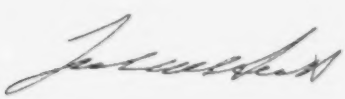
When dollars are scarce, good, reliable data is all the more critical to ensure that the right decisions are made. Year after year, CIHI data has helped inform policy-makers and health system managers on where our health dollars are being spent, which areas are growing the fastest and where improvements can be made.

Data has also helped inform Canadians on the value they are getting in return for their investment dollars. CIHI's data shows that, without question, investment in health care over the past 10 years has brought them more health services. This is particularly true in areas targeted for wait time reductions. Thanks to the reorganization of professional services and physician incentives, the surgical volume of hip replacements in our public system has nearly doubled. Our capacity to treat cancer patients with radiation therapy has increased, as has our imaging ability, a result of having 300% more MRI machines and 70% more CT scanners. With the development of more systematic wait times reporting, we see decreases in waits for cataract and bypass surgery and joint replacements in most provinces where trends can be measured.

Can improvements and efficiencies still be made? Absolutely! Data is critical to understanding which models of care are delivering the best value for money for Canadians, who expect high-quality services at sustainable costs. Investment in data development provides real returns.

No one would think about managing a business without good solid performance data. It's no different in health care. You have to know and understand what's driving costs before you can start to control them. You also have to know how you compare to others. It's through data that we can learn from others and monitor the impact of our improvement efforts. Better information technology, particularly electronic health records, can help us reduce waste and duplication of services. By allowing us to see how patients use the system as a whole, electronic records also hold enormous potential for determining best practices, clinical research, resource planning, monitoring outcomes and the ability to spot and track adverse events.

Yes, this investment costs money up front, but if we're looking to tighten our belts in a way that we don't come to regret later, the best course of treatment is to ensure data is a key player in the process.



Graham W. S. Scott

CIHI at a Glance

Who We Are

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Our Vision

To help improve Canada's health system and the well-being of Canadians by being a leading source of unbiased, credible and comparable information that will enable health leaders to make better-informed decisions.

What We Do

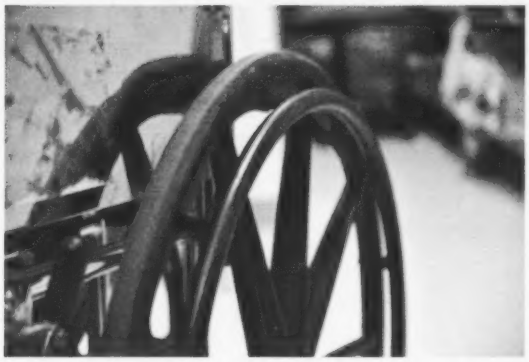
CIHI works with stakeholders to create and maintain a broad range of health databases, measurements and standards. We develop reports and analyses from our own data and other sources. We also work with stakeholders to help them better understand and use our data and analyses in their day-to-day decision-making. We do all of this in a way that ensures privacy and value for Canadians.

Who We Serve

CIHI produces information and analyses that are publicly available for stakeholders in the health system and beyond. When setting priorities among the needs of stakeholders, we concentrate on senior government leaders and others involved in developing health policy; those who lead, manage and plan the delivery of health services at the front line; and members of the general public. We also support those who use data for health and health-services research; health professionals and health-records staff who are involved in the collection of data; and academics who help train our future health leaders.

Where We Are

Contact CIHI



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Our Accomplishments

A few years ago, we conducted broad consultations with our health care partners across the country to identify their top information needs. Based on what we heard, we created a four-year strategic plan to guide our work and focus our efforts through to the end of March 2012. These strategic directions are

- **More and better data:** We will enhance the scope, quality and timeliness of our data holdings.
- **Relevant and actionable analysis:** We will continue to produce quality information and analyses that are relevant and actionable.
- **Improved understanding and use:** We will work with stakeholders to help them better understand and use our data and analyses; we will do this in a timely and privacy-sensitive manner.

Over the last year, we've moved forward on our ambitious plan, but an important part of making progress is being able to measure it, particularly in a data-focused organization. That's why this year's annual report includes a new set of performance targets and measures for priority initiatives that align with our strategic directions.

Overall, we've made significant strides. Many targets were met, some were exceeded and others are well on their way. In this section, you can find out more about our priorities and how we fared in meeting them, with our new indicators included under each strategic direction.

More and Better Data

Solid, reliable data is an asset for any organization. When your core business is health information, that importance is amplified. Decisions about the health care system are based on the information we glean from it—and that's a responsibility we take to heart. As part of our strategic directions, we've made a commitment to our stakeholders to enhance the scope and quality of our 27 databases; here's what we've achieved:

Enhance and Expand Existing Data Holdings

We've made great strides this year in increasing both the breadth and timeliness of our National Ambulatory Care Reporting System (NACRS), which holds data on emergency departments and outpatient services. We continue to receive data from all acute care facilities in Ontario, and this year the database started receiving data from the Winnipeg Regional Health Authority, which covers approximately 75% of all emergency department activity in Manitoba. Alberta is moving forward with province-wide participation, while two facilities in Saskatchewan have also signed on. Quebec is considering doing the same.

With the aging population, understanding the characteristics, care needs and outcomes of individuals receiving continuing care at home, in hospitals and in residential care facilities is more important than ever. Our Continuing Care Reporting System saw the number of facilities regularly submitting data more than double. Our Home Care Reporting System also continued to grow, with more than 600,000 assessments of home care clients across the country.

Given the increasing interest in comparable cost data, we enhanced the Canadian MIS Database to allow for more frequent data submissions, giving jurisdictions access to more useful and timely data for analysis.

To help meet our goal of providing standardized, national data on health professionals beyond physicians and nurses, this past year we released data from two of our newest health human resources databases: the Medical Laboratory Technologist Database and the Medical Radiation Technologist Database.

Explore New Areas and Provide Leadership on Data Standards

Medication incidents are one of the most common adverse events for Canadian patients in our health care system, and reducing their frequency has been identified as a priority from a patient safety perspective. Our National System for Incident Reporting was implemented in 18 hospitals across Canada beginning in late 2008, and it now has more than 3,000 medication incidents. Wider implementation will begin in autumn 2010.

One of the growing areas of importance for our stakeholders is primary health care, as better and more comprehensive patient care up front can lead to fewer complications. Increasingly, primary health care providers are using electronic medical records (EMRs) to better manage and prevent chronic diseases at the clinical level. The use of standardized EMR data can also

help improve care and create efficiencies by measuring the performance and outcomes of primary health care delivery at multiple levels. On this front, we have been working with all jurisdictions across the country and with Canada Health Infoway to determine which content standards are most appropriate for implementation in EMRs at this time, as well as to identify potential adoption challenges. This important initiative is of great benefit to our partners at the jurisdictional level, as it will help reduce duplication and effort in the development, testing and maintenance of EMR content standards. We are also leading the development of other primary health care data sources.

As we move towards a national system of electronic health records (EHRs), we're working to maximize their potential around health system use of data. This involves using health information captured in electronic records across the country for clinical program and health system management, monitoring the health of the public and conducting research, all of which lead to improved patient care and health outcomes. CIHI, Canada Health Infoway and the federal, provincial and territorial governments are working together to ensure that we make the most of current and future investments to help realize this goal. As part of an overall plan, we're developing best practices around data de-identification, setting up the Knowledge Exchange Network and working to develop common standards for the primary health care data collected from electronic medical records. We conducted focus groups and polling to better understand the challenges and opportunities associated with the broader uses of EHR data.

Enhance the Quality and Timeliness of Our Work

While quantity is important, quality is essential to our mandate of providing reliable, comparable data. To this end, we further strengthened our Data Quality Framework. It includes a data holding assessment tool, the model adopted by many Canadian and international organizations.

We enhanced our annual data quality reports for deputy ministers and released them a month early. A collaborative effort with Statistics Canada, these reports provide a snapshot of how jurisdictions are faring in the scope and timeliness of their submission of data. We also provided our stakeholders with relevant information from the data quality studies on the Discharge Abstract Database and the Canadian Organ Replacement Register to assist them in monitoring their own data quality.

As part of the NACRS overhaul, we developed new emergency department indicators and, last July, released the first reports based on those—within three weeks of month end. We've also been working to replace the NACRS quarterly reports that are currently generated up to four months after end of quarter. Our redeveloped NACRS reports, available in June 2010, will be cumulative and produced monthly, providing comparative information within three weeks of month end.

More and Better Data: Performance Measures

As part of CIHI's year-end reporting, the chart below illustrates CIHI's progress in moving forward on the priorities identified in the 2009–2010 operation plan and budget. Overall, the results demonstrate good progress, with many of the targets having been achieved or surpassed.

Increase Emergency Department (ED) Data

Performance Measures	Targets for 2009–2010	2009–2010 (as of March 31, 2010)
Number of sites / facilities / jurisdictions submitting ED abstracts to National Ambulatory Care Reporting System (NACRS) (by reporting level)	Maintain current level of participation in submission of Level 3 ED abstracts At least 20 new sites / facilities from two different jurisdictions will submit ED abstracts (Level 1 data only)	Current level of participation in submission of Level 3 ED abstracts maintained. Ontario: 128 sites from 83 corporations submitting level 1 data Manitoba: As of February 2010, data submitted by all facilities with EDs in Winnipeg Regional Health Authority (six facilities at Level 1, one at Level 3), representing 75% of the province's ED activity.
Percent of all ED visits having submitted an abstract to NACRS (by reporting levels)	40% of all ED visits submitting an abstract to NACRS (Level 1 or 3 data)	As of March 31, 2010, 38% of ED visits were submitted to NACRS (Level 1 or 3 data)

Increase Home Care Data

Performance Measures	Targets for 2009–2010	2009–2010 (as of March 31, 2010)
Number of P/T jurisdictions participating in Home Care Reporting System (HCRS)	5 jurisdictions participating in HCRS	5 jurisdictions (B.C., Manitoba, Nova Scotia, Ontario, Yukon)
Number of regional health authorities submitting RAI-HC data to HCRS	30 regional health authorities submitting RAI-HC data	30 regional health authorities submitting RAI-HC data

Increase Continuing Care Data

Performance Measures	Targets for 2009–2010	2009–2010 (as of March 31, 2010)
Number of P/T jurisdictions participating in Continuing Care Reporting System (CCRS)	6 jurisdictions participating in CCRS	6 jurisdictions (B.C., Manitoba, Nova Scotia, Ontario, Yukon, Newfoundland and Labrador)
Number of facilities / LTC homes submitting RAI-MDS 2.0 data to CCRS	800 facilities / LTC homes submitting RAI-MDS 2.0 data	839 regularly submitting facilities / LTC homes (does not include non-production / historical data submissions)

Increase Pharmaceutical Data

Performance Measures	Targets for 2009–2010	2009–2010 (as of March 31, 2010)
Number of jurisdictions submitting data to National Prescription Drug Utilization Information System (NPDUIS) Database	At least one new jurisdiction will submit drug utilization data to NPDUIS Database	CIHI has received commitment from Ontario to provide drug claim data in Q1 2010–2011 Considerable progress has been made towards establishing a data sharing agreement with First Nations and Inuit Health Branch (FNIHB)

Address Data Gaps in Community Mental Health

Performance Measures	Targets for 2009–2010	2009–2010 (as of March 31, 2010)
No performance measures established	Complete specific project designed to explore options/opportunities to address information needs in the atea of community mental health Develop prototype database for one or two jurisdictions to demonstrate the types of reports, indicators and quality processes that could be implemented with a community mental health reporting system	Scope and nature of data repository to be clarified in 2010–2011, based on findings of Newfoundland and Labrador and Ontario pilots and CIHI consultations on data information

Improve Quality and Use of Financial/Cost Data

Performance Measures	Targets for 2009–2010	2009–2010 (as of March 31, 2010)
No performance measures established	Develop analytical data sets to support analysis and third-party data requests Develop web-based interactive data tables that would provide cost estimates for specific diagnosis and intervention groups Initiate development of patient-specific case-cost database (with expected go-live date of April 2011)	Completed analytical data sets Web-based interactive data tables developed that provide cost estimates for specific diagnosis and intervention groups Prepatory work completed, project on hold

Relevant and Actionable Analysis

Over the last year, we continued to increase the depth and breadth of analysis and reporting across all our data holdings. We developed and released more than 38 analytical products, which included reports on priority themes such as access and quality of care, wait times, health outcomes and continuity of care, as well as special studies on costs and patient safety.

Part of being relevant and actionable is being timely. This past year, H1N1 emerged as the first flu pandemic in more than 40 years. Last February, after the second wave of the flu was over, our Emerging Issues team released a timely and well-received analysis comparing hospitalizations for H1N1 from public health surveillance information with those for pneumonia or flu in a regular flu season. This helped our stakeholders to gauge the impact of the pandemic on the health care system.

In the spring of 2009, the Chalk River, Ontario, nuclear reactor was shut down for repairs, prompting global concerns and headlines about a shortage of medical isotopes for medical imaging. At the request of our stakeholders, we conducted an electronic survey and focus groups to shed light on the impact the supply disruption of isotope Tc-99m was having on patient care in Canada. The results will be released in 2010–2011, just seven months after work got under way.

Given the increasing jurisdictional interest in measuring and comparing hospital performance, we led a successful project aimed at producing pan-Canadian hospital performance comparison reports. These are based on indicators in areas such as clinical care and outcomes, and financial performance. In addition, we continued to work with key partners such as Statistics Canada to develop, compile and disseminate new and enhanced health indicators at the health region level.

In January we released a new generation of quality indicators for continuing care hospitals and residential care homes. These indicators are based on international research and feature new risk-adjustment methods for fairer comparisons of quality across Canada and beyond.

As governments try to curtail the rate of growth in health care spending and look at moving away from global budgets to budgets based on tailoring money to the size and age of communities, we developed a Patient-Cost Estimator. Available on our website, this innovative new tool gives our stakeholders meaningful data on the costs of inpatient health services. The estimator allows average hospital costs by Case Mix Group (CMG) to be calculated at both the provincial and national levels. It presents the estimated average costs of services, along with volumes of patients seen per CMG by jurisdiction and age group.

We continued to work on the Canadian Population Health Initiative Action Plan, which aims to inform policies that reduce inequities and improve the health and well-being of Canadians. It focuses on the factors contributing to healthy weights, the determinants of mental health and resilience, the links between place and health and reducing gaps in health.

We also celebrated an anniversary this year! 2009 marked the 10th anniversary of Health Care in Canada. This special edition of the annual report took a retrospective look at the past decade in health care and focused on key areas of change, such as health spending, access, research and innovation.

High-Impact Studies Released by CIHI

- The third public release of *Hospital Standardized Mortality Ratio* focused on sepsis and found that, in 2008–2009, almost a quarter of all sepsis patients were diagnosed after being admitted to hospitals. Our data found these patients were 56% more likely to die than patients diagnosed with sepsis before their admission to hospital.
- The analysis *Organ Donor Activity in Canada, 1999 to 2008* found that, although the number of organ transplants rose by more than one-quarter (28%) over a 10-year period, it is not keeping up with the demand for organ donations.
- Two new reports, *Wait Times Tables—A Comparison by Province* and *Surgical Volume Trends, 2009*, show the progress jurisdictions are making in meeting wait time benchmarks in priority areas such as joint replacements, cardiac care, cataracts and radiation therapy, as well as whether the focus on priority area procedures has come at the expense of other procedures.
- As part of our work on the *Canadian Population Health Initiative Action Plan*, we released several reports and analyses, including *Mentally Healthy Communities: Aboriginal Perspectives* and *Comparing Activity and Fruit and Vegetable Consumption by Weight Status Among Children and Youth*. The proceedings report from the Mental Health, Delinquency and Criminal Activity workshop was also released. A new flagship report
on place and health will be released next year.
- *Diabetes Care Gaps and Disparities in Canada* analyzed data from the Canadian Community Health Survey (CCHS) and found there is a notable gap between recommended care to prevent complications and the care that patients say they receive.
- *Drug Use Among Seniors on Public Drug Programs in Canada, 2002 to 2008* used data from our National Prescription Drug Utilization Information System Database to examine the claims of more than one million seniors across six provinces. It found that nearly two-thirds of seniors were using five or more drug classes in a year, while one in five were using 10 or more types of prescription drugs.
- The 10th anniversary of our annual *Health Indicators* report, produced in collaboration with Statistics Canada, highlighted improvements in cardiac care across Canada over the past decade, including a reduction in the rate of heart attacks as well as improved hospital outcomes for heart attack patients.

Top 10 Downloads

Rank	Report	Total Download Visits
1	Health Indicators 2009	6,805
2	CPHI Impact of Poverty on Health	6,785
3	Health Care in Canada 2009	6,769
4	Health Care in Canada 2008	5,952
5	Wait Time Tables—A Comparison by Province, 2009	4,231
6	Drug Expenditure in Canada, 1985 to 2008	3,812
7	Wait Time Tables—A Comparison by Province, 2008	3,406
8	Understanding Emergency Department Wait Times	2,805
9	Exploring the 70/30 Split: How Canada's Health Care System Is Financed	2,748
10	National Health Expenditure Trends, 1975 to 2009	2,745

Relevant and Actionable Analysis: Performance Measures

As part of CIHI's year-end reporting, the chart below illustrates CIHI's progress in moving forward on the priorities identified in the 2009–2010 operation plan and budget. Overall, the results demonstrate good progress, with many of the targets having been achieved or surpassed.

Increase Overall Depth, Breadth and Relevance of Analytical Products

Performance Measures	Targets for 2009–2010	2009–2010 (as of March 31, 2010)
Number of regular annual reports produced	19 regular annual reports produced	18 regular annual reports produced
Number of special/topical reports produced	12 special/topical reports produced	6 special / topical reports produced
Number of Analyses in Brief produced	15 Analyses in Brief produced	14 Analyses in Brief produced
Overall measure of each and impact—to be developed	Measures of reach and impact (TBD)	See Data in Action stories for impact

Develop New Comparative Health Indicators in Areas Such as Hospital Performance, Patient Safety, Quality and Access to Care and Public/Population Health

Performance Measures	Targets for 2009–2010	2009–2010 (as of March 31, 2010)
Number of health indicators produced	*Health Indicators 2009* report will contain at least three new/additional CIHI-produced indicators (likely AMI, stroke and hip fracture event rates)	In the 2009 publication, three new indicators that were developed at national, provincial and regional levels were published. These were hospitalized stroke event, hospitalized AMI event and hospitalized hip fracture event. *Health Indicators 2010* will contain two new measures for disparity. These measures will provide rates/ratios at provincial and national levels.

Develop Pan-Canadian Hospital Performance Reports

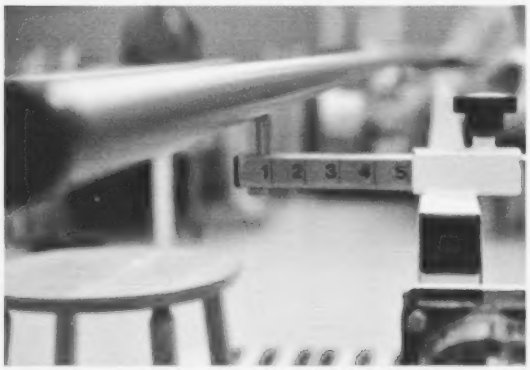
Performance Measures	Targets for 2009–2010	2009–2010 (as of March 31, 2010)
No performance meaures established	Develop prototype pan-Canadian balanced scorecard reports for at least three jurisdictions	Clinical Indicators Preliminary Data Preview: The first draft of the data preview report is ready and being tested Nine jurisdictions have confirmed participation

Improved Understanding and Use

All the data in the world is of little use to anyone if it simply lives in a database without ever being put into action. Ensuring our stakeholders can understand and use the data we collect is as fundamentally important to us as collecting it in the first place.

We are committed to transferring knowledge using an approach that is sustainable and cost-effective. We have started work on a comprehensive new education strategy that will focus and refine our services, with greater emphasis on ensuring high-quality training is provided to the right stakeholders in a timely and efficient manner.

Part of that is always working to increase access, which is why this year we continued to actively promote the adoption and use of CIHI Portal, which houses facility-identifiable data on the delivery of services by hospitals across the country.



We've also expanded and enhanced our eReporting applications for participating facilities. These secure web-based reporting products facilitate the electronic use of quality indicators and other indicators based on several of our data holdings. Produced quarterly, and in some cases monthly, we take a cut of all the data that comes to us from hospitals, long-term care facilities and health regions to produce organization-level comparative reports for the ambulatory care, acute care, rehabilitation, long-term/chronic and home care sectors.

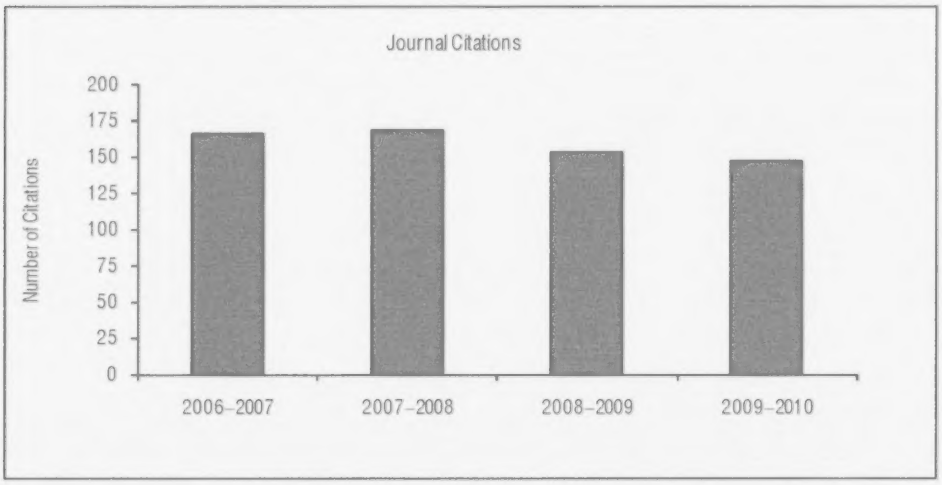
We have also been working hard on a new user-friendly website that will open the door to numerous data and information products. It will launch in the upcoming fiscal year.

Significant effort continues to be put into redeveloping our ambulatory care grouping methodologies to enhance understanding of acute ambulatory care activity and hospital costs. We've been working to provide documentation and workshops on using the acute inpatient grouping methodology (CMG+) for planning and decision-making. New resource utilization reports have also been developed using case mix tools (RUG-III) to help long-term care facilities reporting to the Continuing Care Reporting System better understand their activity.

In a move to further strengthen our external communications and media relations, we created a Speaker's Bureau, which has helped us identify speaking opportunities for our senior leaders, which in turn helps our clients better understand our data and information.

We continued to leverage our regional offices to identify opportunities to align existing CIHI data and products with regional needs. We've also been working with several jurisdictions on enhancing inter-jurisdictional comparisons.

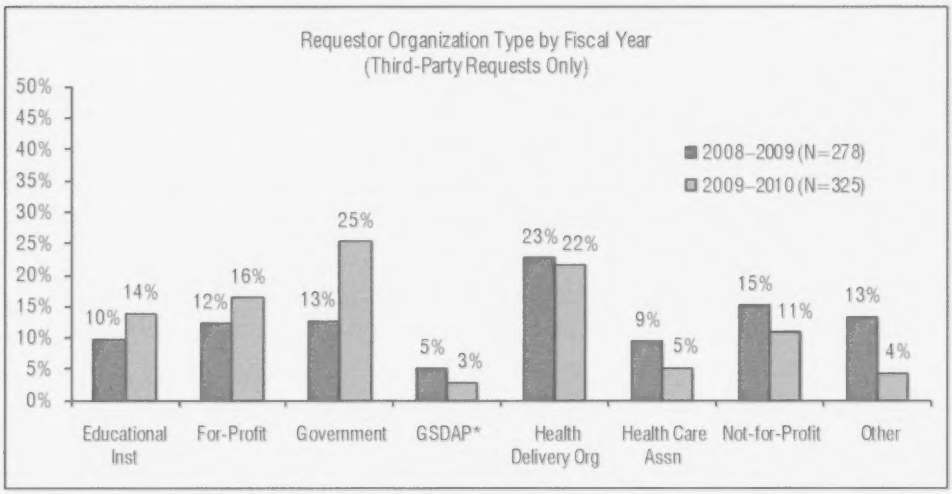
Peer-Reviewed Journal Citations



Media Hits

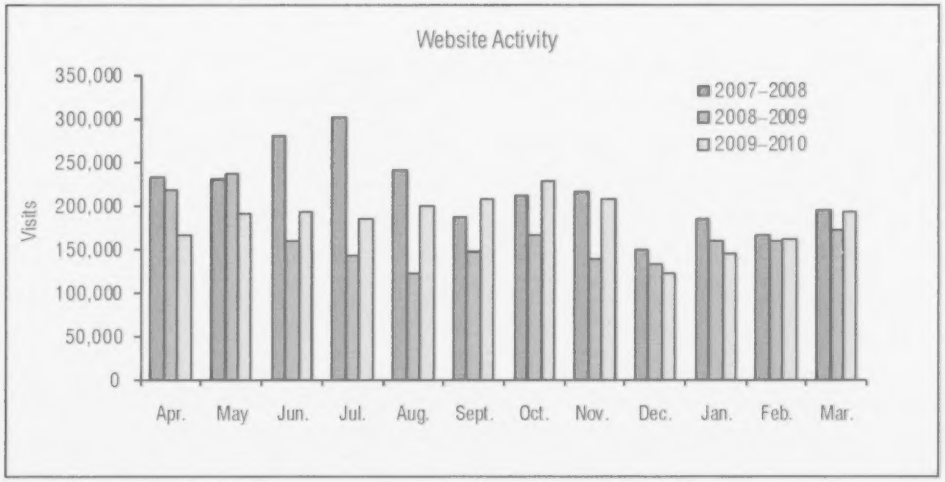
Fiscal Year	Print Articles (From Releases/ Advisories)	Print Articles (Unsolicited)	Broadcast Items	Web Items (Releases and Unsolicited)	Total Items	Total Circulation/ Audience Reach (Millions)
2007–2008	1,109	353	952	871	3,285	124.3
2008–2009	512	370	364	951	2,197	210.2
2009–2010	619	322	520	1,508	2,969	616.8

Data Requests

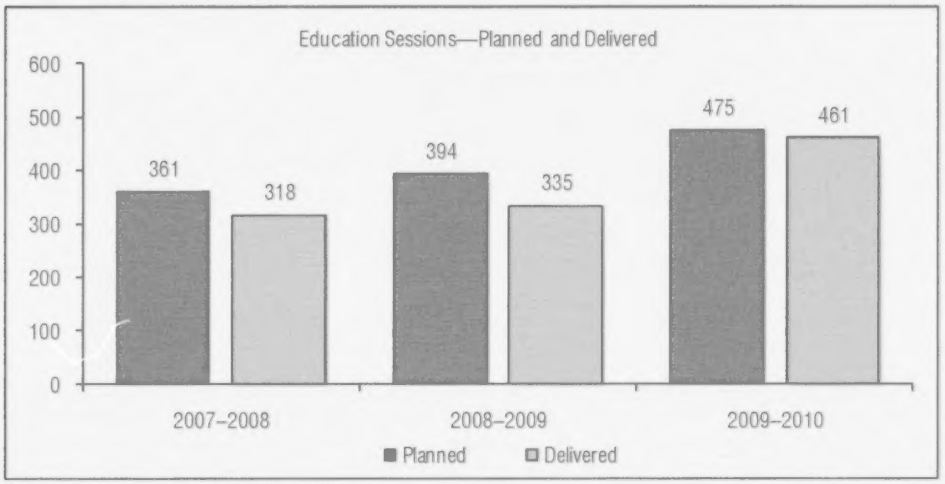


* Graduate Student Data Access Program.

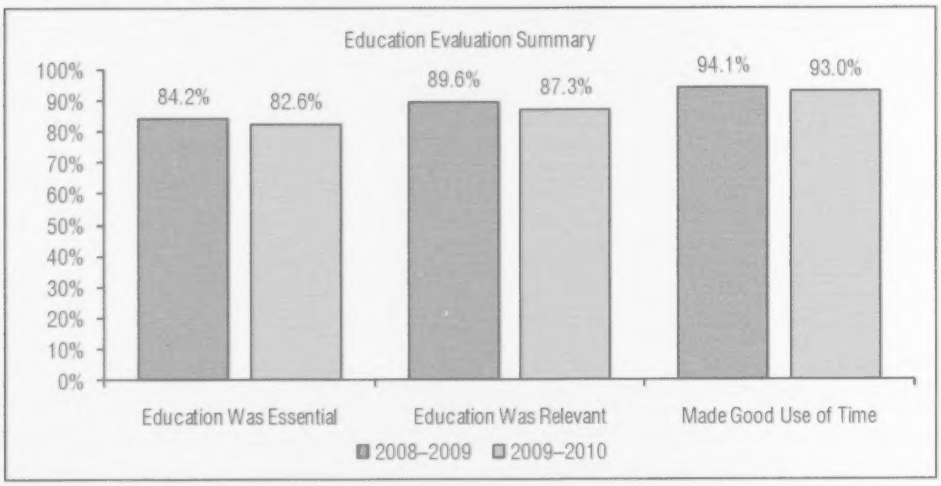
Website Activity



Education Sessions



Education Evaluation Summary



Improved Understanding and Use: Performance Measures

As part of CIHI's year-end reporting, the chart below illustrates CIHI's progress in moving forward on the priorities identified in the 2009–2010 operation plan and budget. Overall, the results demonstrate good progress, with many of the targets having been achieved or surpassed.

Continue Work on Redevelopment of CIHI's Website

Performance Measures	Targets for 2009–2010	2009–2010 (as of March 31, 2010)
No performance measures established	Launch redesigned external website with improved navigation and more comprehensive, up-to-date and easier-to-retrieve content	Intranet site launched Content management process delivered for intranet content

Develop (and Provide Access to) New eReporting Tools/Reports/Indicators

Performance Measures	Targets for 2009–2010	2009–2010 (as of March 31, 2010)
Number of eReporting tools available to clients	Addition of three new eReporting applications	Six new eReporting tools were added: - The Hospital Standardized Mortality Ratio Indicator Dashboard - NACRS ED Wait Times eReporting solution - National Rehabilitation Reporting System (NRS) eReporting solution - MIS ad hoc eReporting in CIHI Portal - The Patient Cost Estimator Dashboard - Home Care Reporting System (HCRS) eReporting Solution

Increase Adoption/Uptake of CIHI Portal

Performance Measures	Targets for 2009–2010	2009–2010 (as of March 31, 2010)
Number of participating sites Number of registered users	60 participating sites 315 registered users	There are 46 sites and 236 registered (named) users of Portal in eight provinces and two territories P.E.I. and Quebec are piloting Portal

Increase Number of Data Offerings in CIHI Portal

Performance Measures	Targets for 2009–2010	2009–2010 (as of March 31, 2010)
Number of data marts available in CIHI Portal	Addition of one new data mart	MIS data mart was added to Portal

Increase Number and Reach of Educational Offerings

Performance Measures	Targets for 2009–2010	2009–2010 (as of March 31, 2010)
Number of face-to-face workshops offered	200 face-to-face workshops offered	205 face-to-face educational workshops delivered
Number of registrations (for all educational offerings)	12,000 registrations (for all educational offerings)	Growth was noted in all modes of education with total registration numbers increasing to 22,677 using new and more detailed reporting measures which have been instituted. Using the previous method of counting these registrations, the total number would have been 16,846.

Privacy

On average, we receive close to five million records a month on drug data alone. In the case of the Discharge Abstract Database, that number is more in the vicinity of 250,000 records a month. These numbers, among many others, are staggering and, in the end, make our data holdings tremendously rich sources of information. From a privacy perspective, these numbers translate into sensitive personal information about Canadians.

The soundness of our Privacy and Security programs is therefore vitally important. It has enabled us to become a reliable and trustworthy information manager across the country—one that is committed to maintaining the highest standards in safeguarding the important and sensitive personal health information entrusted to us.

In the last year, we developed and implemented a Privacy and Security Framework to ensure a coherent and comprehensive approach to enterprise-wide privacy and security. Moreover, we adopted and implemented a new Privacy Policy that accurately reflects privacy requirements, standards and best practices across the country.

Our Organization

The successes captured in this report are the work of the talented, dedicated and creative people who make up our organization. We are tasked with meeting the ever-expanding information needs of a large and complex health system that runs at full steam 24 hours a day, 7 days a week, 365 days a year. Needless to say, filling information gaps is a full-time job, but our people are always up to the task.

Good people are hard to find, and we certainly want to keep ours. That's why we've made retention a key component of our new talent management strategy. Beyond that, the strategy focuses on how our organization can successfully plan and manage our talent through the employee life cycle of recruitment, development and career transition.

In order to keep our employees motivated and engaged in their work at CIHI, having a positive, supportive culture is certainly an asset. We were encouraged once again by the very positive results of our biennial employee satisfaction survey. We received great feedback from staff at all levels, with ratings far above others in the public and private sectors.

Looking Ahead

While we've accomplished a great deal, we still have a lot more work to do. We're eager to build on recent successes to continue to respond to the information needs of our stakeholders. In the upcoming year, we will remain focused on our strategic priorities of gathering more and better data, producing relevant and actionable analysis and improving our clients' understanding and use of CIHI data and information products.

More and Better Data

- Increase jurisdictional uptake of select reporting systems, with a continued focus on home and continuing care, pharmaceuticals, medication incidents and ambulatory care/emergency visits
- Continue to develop and implement our Primary Health Care Information program
- Work to address data gaps in the areas of Aboriginal health and community mental health
- Increase the quality and comprehensiveness of our patient-specific cost data
- Improve the timeliness of data collection and reporting across all data holdings
- Collaborate with jurisdictions and Canada Health Infoway to advance health system use of data and the pan-Canadian agenda related to the electronic health and medical records

More Relevant and Actionable Analysis

- Produce our first-ever pan-Canadian hospital reports
- Release a series of analytical products on cross-cutting themes focused on cancer, seniors, Aboriginal health, mental health and patient safety/quality of care
- Develop and implement a rolling multi-year analytical plan and release reports and special studies focused on access to care/wait times, patient outcomes, H1N1, continuity of care, cost/productivity and primary health care
- Implement methodologies and infrastructures to link data in a privacy-sensitive manner
- Continue to implement the *Canadian Population Health Initiative Action Plan*, with a particular focus on the themes of place and health and reducing gaps

Understanding and Use of Our Data

- Expand the depth and breadth of our eReporting applications, including CIHI Portal
- Launch our new and improved website
- Share expertise and enhance overall responsiveness by implementing a more strategic approach to marketing products and developing a customer strategy and educational offerings
- Develop new data sharing agreements, as appropriate
- Enhance our data security and privacy programs by conducting privacy audits on select internal data holdings and external data recipients
- Host national conferences and workshops to promote increased understanding and use of our data and information products
- Develop and deliver education products to support improvement and use of our products and services (such as data quality, national reporting system, indicators and data standards)

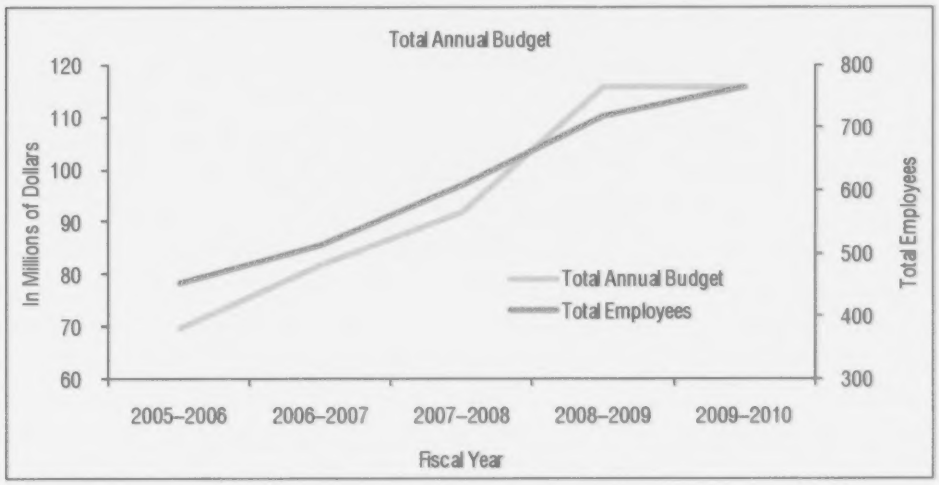
Next fiscal year is the third year in our four-year strategic plan. Equally important, it's the fourth year of our five-year funding agreement with Health Canada. As part of our transparency and accountability to Canadians, we will be completing what we expect to be a successful and insightful third-party evaluation of the Health Information Initiative and a performance audit, as required by the funding agreement. We're also already working on a new action plan for renewing our long-range strategic plan and funding.

Management Discussion and Analysis

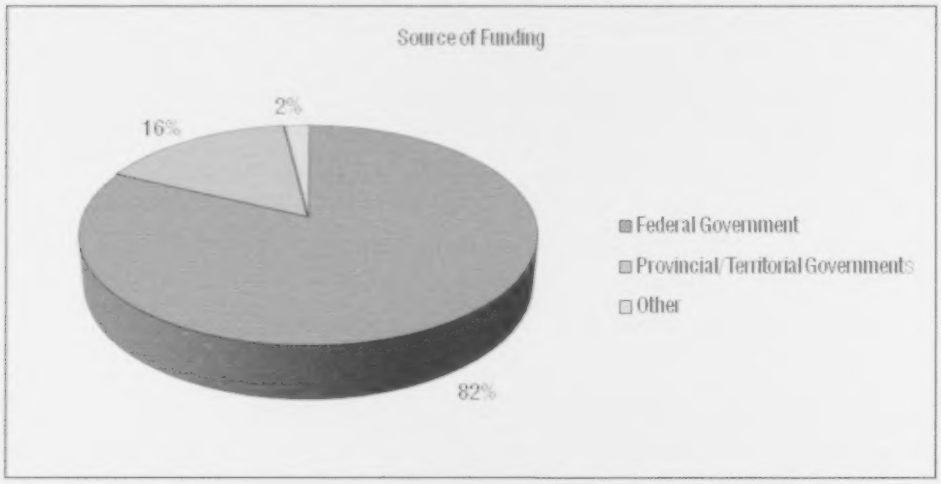
The following section provides an overview of our operations and some explanations of the financial statements; it should be read in conjunction with those statements. They were prepared by management in accordance with Canadian generally accepted accounting principles. Management is responsible for the integrity and reliability of the data in the financial statements and maintains a system of internal controls that provides reasonable assurance as to the reliability of the financial information and safeguarding of assets.

The Board of Directors is responsible for ensuring that management carries out its responsibility for financial reporting and internal controls; it exercises this responsibility through the Finance and Audit Committee (FAC), the members of which are independent of management. The FAC meets regularly during the year with management and the external auditors, Ernst & Young LLP. The external auditors conduct an independent audit in accordance with Canadian generally accepted auditing standards and express an opinion on the financial statements. The FAC reviews the financial statements and recommends their approval by the Board of Directors. For 2009–2010 and 2008–2009, Ernst & Young issued unqualified opinions. For all previous years, unqualified opinions were received from the external auditors.

Established in 1994 as an independent not-for-profit organization, CIHI has continuously grown. Over the last five years, our annual total budget, which consists of the operating and capital resources requirements, as well as the financing of our pension plans, increased by 65% to reach a financial level slightly higher than $100 million.



Our ongoing programs and new initiatives are managed within the terms and conditions of the federal, provincial and territorial agreements that provide most of our annual budget revenue.



Since 1999, Health Canada has significantly funded, through a series of grants and contribution agreements referred to as the Roadmap Initiative or Health Information Initiative, the building of a comprehensive national health information system and infrastructure to provide Canadians with the information they need to maintain and improve Canada's health system and the population's health.

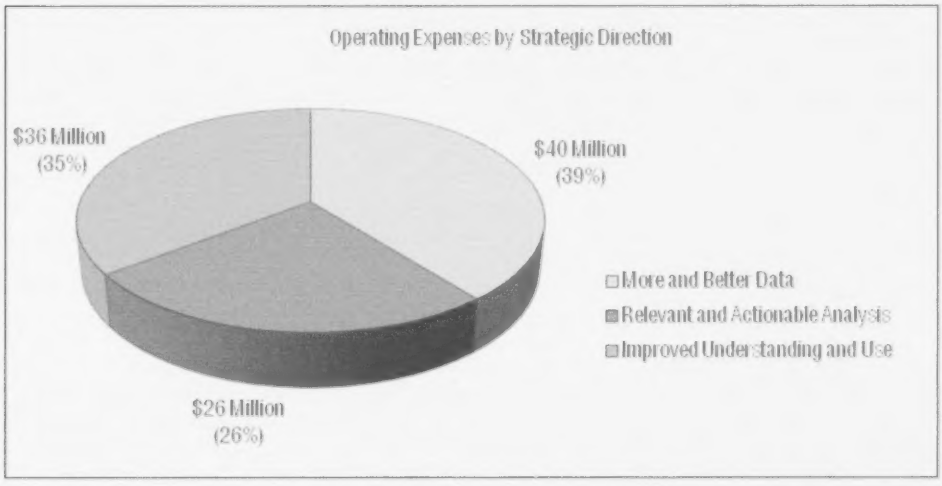
Management Explanation of Results

The total operating revenue for 2009–2010 amounted to $102.5 million, compared to $109.2 million for the previous year. The variance related mainly to the depletion of the Roadmap Initiative funds, more specifically for the Canadian Population Health Initiative and the Canadian Health Measures Survey project. These funds were received from Health Canada prior to 2007–2008 in the form of global direct payments.

Our operating expenditures this past year totalled $102.3 million. These were composed of $64.4 million in salary and employee benefits (63%) and $37.9 million in non-salary expenditures (37%). This is comparable to $61.2 million (56%) and $47.9 million (44%), respectively, in 2008–2009. The variance is mainly related to hiring additional resources to support our increasing program of work.

Total remuneration, including any fee allowance or other benefits to our senior management team involved in continuously accomplishing our strategic directions, represented $4.4 million for 2009–2010.

Investments in our three strategic directions remained relatively constant with 2008–2009, as a proportion of the total operating expenses.



Acquisition of capital assets for 2009–2010 amounted to $3.3 million and was mainly related to computer hardware, software and telecommunications. This represents a significant decrease from 2008–2009, where capital assets acquisitions totalled $15.6 million. These included significant investments in furniture and leasehold improvements for the new Toronto office and expanded offices in Ottawa and Montréal, as well as a new telephone system and web, content and business management software and hardware.

Roadmap Investments

For effective and prudent management of our investments, we hired TD Asset Management Inc. as the custodian and investment manager. At the end of March 2010, $15.5 million had been invested in TD Emerald Canadian Treasury Management pooled funds, which include low-risk financial instruments, such as GICs, treasury bills and commercial papers. We adhere to investment best practices and policies similar to those endorsed by the federal government investment guidelines. An appropriate benchmark was established to measure the performance of the funds and the investment manager. To ensure stewardship of the funds, the FAC periodically reviews the results and rate of return of the funds.

Pension Plans

We sponsor a contributory defined benefit plan that offers our employees annual retirement income based on length of service and final average earnings. Contributions are determined by actuarial calculations and are dependent on employee demographics, rate of turnover, mortality, investment return and other actuarial assumptions. CIHI and employee contributions are invested in pooled funds and professionally managed in accordance with the *Statement of Investment Policies and Procedures*.

There are two valuations prepared for the plan: one for accounting purposes (see note 8 of the financial statements) and one for funding purposes used for regulatory purposes and management of the plan. The valuations for accounting and funding purposes are prepared at different times and use different assumptions. Based on accounting standards prescribed by the Canadian Institute of Chartered Accountants, on March 31, 2010, the plan reported a surplus of $3.8 million, compared to a deficit of $1.9 million in 2008–2009. On a funding basis, the plan had a deficit of $4.7 million on January 1, 2010, compared to a deficit of $2.1 million on January 1, 2009. The past few years' economic turmoil had a significant impact on the plan's funding valuation. Management and the FAC continue to monitor the economic environment and are taking the necessary steps to address the unfunded liability.

In addition to the contributory defined benefits, we supplement the benefits of employees participating in the plan who are affected by the application of the *Income Tax Act*'s maximum pension limit. The supplementary plan is not pre-funded and we make benefit payments as they become due. These benefits are accrued and recognized in our financial statements in accordance with applicable accounting rules.

Internal Audit Program

We have an internal audit program that includes evaluating compliance with administrative policies, procedures and government regulations, assessing the overall effectiveness of controls and processes currently in place and identifying opportunities for improvement. The internal audit activities vary in scope and evolve over time to focus on areas of greatest risk to the organization. In 2009–2010, activities included audits of landlord operating expenses, consumption taxes, employee benefits, travel and telecommunication expenses, vendor licence end-user fees and third-party data requests. Assessments of corporate fraud risk and information technology hardware and systems testing and vulnerability were also performed. Targeted action plans were developed to address the areas for improvement recommended by the auditors and consultants contracted by us to specifically perform the activities.

Risk Management

At CIHI, we're not averse to taking risks—we just want to make sure they're reasonable, manageable and based on risk tolerance. Our approach is to be proactive and mitigate where we can. CIHI's risk management program ensures management excellence, strengthened accountability and improved future performance. It also supports planning and priority-setting, resource allocation and decision-making. We focus on risks that cut across the organization, are linked to our strategic directions, are likely to remain for the next three to five years and can be managed by our senior leadership.

Our Risk Management Framework consists of the following four processes, which are geared towards achieving CIHI's strategic directions:

Risk Management Activities

This past year our senior management team assessed a number of key risks that could prevent us from achieving our strategic directions, based on their likelihood of occurrence and their potential impacts. Four of these were identified as corporate risks, due to their high level of residual risk (risk level after considering existing mitigation strategies).

Information Product Timeliness

We continued to work hard this past year to meet stakeholder expectations for more timely dissemination of key information products. We've put a plan in place and have already made significant progress. For example, we are now providing comparative reports on emergency department wait times on a monthly basis and getting them into the hands of our stakeholders within three weeks of month end, as opposed to just quarterly as in previous years. We also focused on timely analysis, which saw us release a report on the impact of H1N1 hospitalizations compared to a typical flu year less than six weeks after the end of the pandemic.

Data Flows/Gaps

Data flow involves the movement of data in and out of CIHI, including the uptake of new data holdings. We must meet those new information needs to remain relevant. A new Home Care Reporting System data standard for release in early 2010–2011 will provide a snapshot of all individuals being referred to home care at their first point of contact. This will fill current data gaps on short-term home care clients and those in hospital waiting for discharge to other levels of care. Stakeholders have shown a keen interest in submitting data on emergency department activities. As well, data that covers 75% of Manitoba emergency department activities has started to flow to us. Alberta has also confirmed it will submit emergency department and ambulatory data to us in 2010–2011, and Quebec is seriously considering doing the same in the coming year. Two facilities in Saskatchewan are also moving forward with emergency department data submissions in 2010–2011. In terms of filling new information needs, we conducted a survey on the potential impact of the medical isotopes supply disruption in Canada. We will release those results early in the new fiscal year.

Electronic Health Record/Electronic Medical Record

The implementation of the electronic health record/electronic medical record (EHR/EMR) across Canada represents both an opportunity and a threat. It's an opportunity for us to collect additional data to support health system analyses. But it also poses a possible threat if that data is not collected properly. We have taken a leadership role and gained jurisdictional support in moving critical aspects of the health system use initiative forward. Specifically, in collaboration with Canada Health Infoway and the provincial/territorial jurisdictions, we were successful in getting support from the Conference of Deputy Ministers (CDM) for a formal plan to move this agenda forward through the implementation of the EHR/EMR. We sponsored and took a leadership role in key projects identified in the plan to the CDM, including developing standards for the primary health care data that will be included in EMRs.

Stakeholder Support

Decentralization of authority in the Canadian health care system has created challenges for constituencies to work together and make use of pan-Canadian data and analyses. This environment has provided us with the opportunity to demonstrate commitment to providing value-added products and services for our provincial, territorial and federal stakeholders.

Through our participation in jurisdictional information committees that focus on the use of health information and emerging opportunities, we have expanded participation and awareness of our various data holdings, products and reports.

Data in Action

CIHI Data: Helping Hospitals Reduce Mortality

Barbara Kendrick

At Southlake Regional Health Centre, early results from CIHI's hospital standardized mortality ratio (HSMR) steered staff to look more closely at septicemia. Although sepsis mortality rates were lower than the national average, medical staff at the Newmarket, Ontario facility questioned whether deaths due to other diagnoses, which were above average, might also be attributable to sepsis.

Barbara Kendrick, Southlake's director of quality and planning, says a review of all septicemia cases confirmed there might be a delay in identifying sepsis, as protocols for early identification and treatment were not consistent across the hospital. A task force was created to adopt known best practices and draft standardized orders for early recognition and treatment on the wards and in the emergency room.

"The key was to shorten the time to treatment," Kendrick says.

The hospital also turned to its rapid response team (RRT), an outreach of the intensive care unit, comprised of a critical care nurse and a respiratory therapist. Nurses were trained to recognize sepsis early and instructed to call in the team if they sensed a patient wasn't doing well. As a result, developing cases on the ward are being picked up more quickly and treatment started sooner, which has reduced ICU admissions.

Kendrick says this has been a key patient safety initiative at Southlake, where the sepsis philosophy is now to treat as early as possible.

"The HSMR was instrumental in providing us with a key starting point to assess our mortality rates," says Kendrick. "As a result of our new protocol, we've seen a steady downward trend in our HSMR, and I think we've yet to see the full outcome of the work that we've done over the past year with sepsis."

CIHI Indicators: Putting Quality Measurement Into Practice

Dr. Alan Katz

Dr. Mark Duerksen is a pioneer of the information age in family practice.

As president of the Steinbach Family Medical Center in Manitoba, he's been using electronic medical records (EMRs) for 11 years. His facility is also among the first in Canada to build quality measurement directly into physicians' practices with primary health care (PHC) indicators.

Developed by the Canadian Institute for Health Information, PHC indicators allow care providers to use EMR data to measure many aspects of their practices.

Prior to incorporating the indicators, Duerksen says his group practice had no systemic approach to preventive screening and management of chronic conditions, such as diabetes and hypertension. Now, each doctors' screening rates are pulled from the EMR every three months.

"We found that data itself is motivating. You start looking at what processes need to be put in place to improve," he says.

To foster more comprehensive and preventive care, Steinbach's software features reminders alerting physicians to required tests and exams. Even if a patient visits for a sore ankle, a screen will pop up on Duerksen's monitor, notifying him that she's due for a cholesterol test and a Pap smear. He can now track how consistently his patients are getting these tests.

The PHC indicators have been essential road signs on Manitoba's primary health care renewal journey, specifically its Physician Integrated Network (PIN), of which Duerksen's group has been a part.

"We can't demonstrate quality unless we have indicators against which we can measure," says Jeanette Edwards, special advisor to the deputy minister on primary care, Manitoba Health. "We adopted those indicators and we've learned a lot."

She notes the combination of the EMR and indicators has also led many physicians to better understand their patient population.

"Before this, we treated individual patients. Now we have this overall practice profile, which helps in thinking about where we can make improvements," Duerksen says. "And when we make an intervention, it's nice to have data to know if it's worked."

PIN results speak for themselves. At one clinic, colorectal cancer screening increased more than 31% over phase one, while at another, diabetes screening is up 44% and hypertension monitoring increased almost 17%.

"The indicators have been fundamental," says Dr. Alan Katz, associate professor of family medicine and community health sciences at the University of Manitoba. "The process of collecting (data for them) has had a huge impact on how physicians use the EMR to the benefit of the patient. There has been a change in understanding as to the responsibility physicians have for care. We have people thinking on a population-at-risk basis."

CIHI Data: Helps Heal Hips Faster

Dr. Eric Bohm

For three years in a row, CIHI's annual *Health Indicators* report showed that hip fracture patients in the Winnipeg Regional Health Authority (WRHA) were waiting longer for surgery than in most other Canadian health regions.

"Although we have one of the lowest rates of hip fracture on a population basis, we had one of the worst rates of getting them to the operating room within 72 hours," says Dr. Mike Moffatt, WRHA's Executive Director of Analysis and Research Support.

Although doctors had raised the issue before, CIHI's reports caught the attention of senior management of the region and Manitoba Health. Work soon got under way to reduce wait times to repair broken hips, as research shows longer waits can increase the risk of complications and death.

To stress the need for timely procedures, the health authority held continuing education sessions for staff. The long-standing practice of easing patients off blood thinners and working to stabilize other health issues before surgery also changed, as evidence shows hip fracture patients have better results if surgery is sooner, rather than later, regardless of blood thinner use.

The region developed a real-time information system to provide information about hip fracture patients waiting at every facility across the region. Surgery slates were reorganized and new guidelines developed to reclassify hip fracture patients when their surgery is bumped by urgent procedures. The following day, they now go to the top of the list, says Dr. Eric Bohm, chair of WRHA's orthopedic standards committee and medical advisor to its orthopedic wait list.

He says they're now seeing shorter waits in their internal tracking.

"I'm quite optimistic. This is exactly the kind of stuff CIHI should be doing. This is what causes changes within the system."

CIHI Data: Helps Create a Stroke Care Continuum

Nancy Tunnicliffe

Bruyère Continuing Care is Ottawa's largest provider of inpatient stroke rehabilitation and aims to help patients recover as much function as possible. With more than 300 stroke patients coming through its doors each year, the centre focuses on quality care and aims to ensure that the right patient is in the right bed at the right time.

There was a time, however, when that was easier said than done.

In 2006, data from CIHI's National Rehabilitation Reporting System (NRS) showed that stroke patients at Bruyère had an average length of stay that was 22 days longer than Canadian peer facilities. At the same time, a report from Ontario's Ministry of Health and Long-Term Care found the centre had the most costly rehab beds in the province.

This definitely created a sense of urgency in the organization's management.

One of the goals management set was to reduce the stroke rehab length of stay to within two days of that at peer facilities.

Staff started digging into the data and studying the processes at other institutions in Ontario to see what was working elsewhere. They then examined Bruyère's processes, including admitting and discharging criteria, coding and training, as well as the software being used to capture the NRS data. The goal was to incorporate data into decision-making, care planning and performance measurement, as well as to link it to best practices.

Staff engagement at all levels was critical, so an NRS working group was established and an ongoing educational program formalized.

A close look at its stroke patient population using NRS data revealed that there were two outlying groups that swayed Bruyère's overall length of stay: low-functioning patients who required intense care and high-functioning patients who should have been treated as outpatients. To address this, Bruyère closed 8 inpatient rehabilitation beds and opened 18 low-intensity stroke rehabilitation beds in its complex continuing care program and an ambulatory stroke rehabilitation outpatient program. This reorganized care into a continuum of three interconnected programs: low intensity, high intensity and ambulatory stroke rehabilitation.

Admission criteria, including data-based patient function scores, were established for each program to ensure patients would go where their needs would be best met.

With the goal of rehab being reintegration into the community, discharge is now top of mind—even at admission. Data-informed support tools were created to assist staff in monitoring patient progress, while Bruyère's software was upgraded to incorporate flags that alert clinical staff of each patient's current length of stay and the provincial discharge length of stay for comparable patients. It also flags when a patient length of stay is two weeks away from the point where 98% of similar patients are discharged. These software upgrades help staff to plan and project patient discharge. Today, front-line staff routinely use NRS data to assist in clinical decision-making. Management views the data as a key element in forming policy and improving efficiency and effectiveness.

What's more, the length of stay of high-intensity stroke patients is now within two days of peer NRS facilities. Nancy Tunnicliffe, an NRS coordinator who worked on the overhaul, says that although the data is not an end unto itself, the improvements they've made wouldn't have been possible without it.

"The data was instrumental in terms of demonstrating that sense of urgency and getting the key players on board to start change. There is no way to show that unless you have data."

Financial Statements
Canadian Institute for Health Information

Auditor's Report
To the Board of Directors of the
Canadian Institute for Health Information

We have audited the balance sheet of the **Canadian Institute for Health Information** (CIHI) as at March 31, 2010, and the statements of revenue and expenses, changes in net assets and cash flows for the year then ended. These financial statements are the responsibility of CIHI's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of CIHI as at March 31, 2010, and the results of its operations and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles. As required by the *Canadian Corporations Act*, we report that, in our opinion, these principles have been applied on a basis consistent with that of the preceding year.

Ottawa, Canada
May 7, 2010

Ernst & Young LLP

Chartered Accountants
Licensed Public Accountants

Balance Sheet

As at March 31

	2010 $	2009 $
Assets		
Current		
Cash and cash equivalents *(note 3)*	18,924,509	12,170,262
Accounts receivable *(note 4)*	1,515,540	2,953,593
Prepaid expenses	2,197,725	1,855,404
	22,637,774	16,979,259
Investments—Roadmap *(note 5)*	15,475,008	24,475,712
Capital assets *(note 6)*	20,500,547	21,967,610
Other assets *(note 7)*	401,187	304,496
Accrued pension benefit asset *(note 8)*	3,846,500	—
	62,861,016	63,727,077
Liabilities		
Current		
Accounts payable and accrued liabilities *(note 10)*	10,818,763	10,502,058
Unearned revenue	5,910,541	2,682,358
	16,729,304	13,184,416
Accrued pension benefit liability *(note 8)*	498,700	2,467,500
Deferred contributions *(note 11)*		
Expenses of future periods	20,393,230	21,300,252
Capital assets	17,174,550	18,435,767
Lease inducements *(note 12)*	3,120,262	3,600,172
	57,916,046	58,988,107
Commitments *(note 17)*		
Net Assets		
Invested in capital assets	2,115,133	2,086,753
Unrestricted	2,829,837	2,652,217
	4,944,970	4,738,970
	62,861,016	63,727,077

See accompanying notes

On behalf of the Board

Director

Director

Statement of Revenue and Expenses

Year ended March 31

	2010 $	2009 $
Revenue		
Core Plan *(note 13)*	15,891,245	15,421,872
Sales	1,628,308	2,088,363
Funding—other *(note 14)*	3,375,388	3,939,369
Health Information Initiative/Roadmap	81,399,875	87,539,068
Interest	52,101	182,441
Miscellaneous	125,723	77,364
	102,472,640	109,248,477
Expenses		
Compensation	64,377,574	61,176,178
External and professional services	12,701,937	12,390,290
Travel and advisory committee expenses	4,707,036	5,148,340
Office supplies and services	11,806,929	12,792,661
Computers and telecommunications	7,206,292	6,016,980
Research grants and contributions	1,194,886	11,131,604
Miscellaneous	271,986	457,424
	102,266,640	109,113,477
Excess of revenue over expenses	206,000	135,000

See accompanying notes

Statement of Changes in Net Assets

Year ended March 31

	Invested in Capital Assets	Unrestricted	2010	2009
	$	$	$	$
Balance, beginning of year	2,086,753	2,652,217	4,738,970	4,603,970
Excess (deficiency) of revenue over expenses	(664,615)	870,615	206,000	135,000
Net investment in capital assets	692,995	(692,995)	—	—
Balance, end of year	2,115,133	2,829,837	4,944,970	4,738,970

See accompanying notes

Statement of Cash Flows

Year ended March 31

	2010 $	2009 $
Operating Activities		
Excess of revenue over expenses	206,000	135,000
Items not affecting cash		
Amortization of capital assets	4,693,028	3,896,631
Amortization of lease inducements	(479,910)	(467,207)
Pension benefits	(5,815,300)	(1,302,717)
Amortization of deferred contributions—capital assets	(3,860,979)	(2,991,060)
Loss on disposal of capital assets	66,792	218,904
	(5,190,369)	(510,449)
Net change in non-cash working capital items *(note 15)*	4,640,620	5,222,952
Net change in other assets	(96,691)	(39,950)
Net increase (decrease) in deferred contributions	1,692,740	(2,094,769)
Cash provided by operating activities	1,046,300	2,577,784
Investing Activities		
Acquisition of capital assets	(3,301,037)	(15,574,054)
Proceeds on disposal of capital assets	8,280	4,850
Acquisition of investments—Roadmap	(62,850)	(5,398,350)
Proceeds on disposal of investments—Roadmap	9,063,554	20,041,940
Cash provided by (used in) investing activities	5,707,947	(925,614)
Financing Activities		
Lease inducements received	—	1,961,784
Lease inducements reimbursed	—	(7,440)
Cash provided by financing activities	—	1,954,344
Net cash inflow	6,754,247	3,606,514
Cash and cash equivalents, beginning of year	12,170,262	8,563,748
Cash and cash equivalents, end of year	18,924,509	12,170,262
Represented by		
Cash	2,924,509	8,170,262
Short-term investments	16,000,000	4,000,000
	18,924,509	12,170,262
Supplementary information		
Interest received	112,763	994,927
Interest paid	—	1,361

See accompanying notes

Notes to Financial Statements
March 31, 2010

1. Organization

The Canadian Institute for Health Information (CIHI) is a national not-for-profit organization incorporated under Part II of the *Canada Corporations Act*.

CIHI's mandate is to serve as the national mechanism to coordinate the development and maintenance of a comprehensive and integrated approach to health information for Canada. It also provides and coordinates the provision of accurate and timely data and information required for the establishment of sound health policy; the effective management of the Canadian health system; and generating public awareness about factors affecting good health.

CIHI is not subject to income taxes.

2. Accounting Policies

These financial statements have been prepared in accordance with Canadian generally accepted accounting principles.

The following are the significant accounting policies:

Revenue Recognition

CIHI follows the deferral method of accounting.

Funding contributions are recognized as revenue in the same period as the related expenses are incurred. Amounts approved but not received at the end of the period are recorded as accounts receivable. Excess contributions which require repayment in accordance with the agreement are recorded as accrued liabilities.

Contributions provided for a specific purpose and those restricted by a contractual arrangement are recorded as deferred contributions and subsequently recognized as revenue in the same period as the related expenses are incurred.

Contributions provided for the purchase of capital assets are recorded as deferred contributions—capital assets and subsequently recognized as revenue over the same terms and on the same basis as the amortization of the related capital assets.

Interest revenue is recorded as period income on the basis of the accrual method.

Restricted investment revenue and investment losses on restricted contributions are debited or credited to the related deferred contributions account and recognized as revenue in the same period as eligible expenses are incurred.

Investments

Investments are recorded at fair value determined based on the unit values of the pooled funds as supplied by the respective investment manager. The unit values in pooled funds are based on the market values of the underlying investments.

Capital Assets

Capital assets are recorded at cost and are amortized on a straight-line basis over their estimated useful lives as follows:

Computers	5 years
Furniture and equipment	5 to 10 years
Telecommunication equipment	5 years
Leasehold improvements	Term of lease

Lease Inducements

Lease inducements, consisting of leasehold improvement allowances, free rent and other inducements, are amortized on a straight-line basis over the term of the lease.

Roadmap Expenditures

Roadmap contributions to Statistics Canada are expensed when funds are disbursed.

Pension Benefits

The actuarial determination of the accrued benefit obligations for pensions uses the projected benefit method prorated on service, which incorporates management's best estimate of future salary levels, other cost escalation, retirement ages of employees and other actuarial factors.

For the purpose of calculating the expected return on plan assets, those assets are valued at fair value.

Actuarial gains or losses arise from the difference between actual long-term rate of return on plan assets for a period and the expected long-term rate of return on plan assets for that period or from changes in actuarial assumptions used to determine the accrued benefit obligation. The excess of the net accumulated

actuarial gain or loss over 10% of the greater of the benefit obligation and the fair value of plan assets is amortized over the average remaining service period of active employees. The average remaining service period of the active employees covered by the registered pension plan is 13 years (2009—13 years). The average remaining service period of the active employees covered by the supplementary retirement plan is 12 years (2009—12 years).

Foreign Currency Translation

Revenue and expenses are translated at the exchange rates prevailing on the transaction date. Any resulting foreign exchange gains or losses are charged to miscellaneous income or expenses. Foreign currency monetary assets and liabilities are translated at the prevailing rates of exchange at the balance sheet date.

Use of Estimates

The preparation of financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the year. Actual results could differ from management's estimates as additional information becomes available in the future.

The estimated useful lives of capital assets and the amount of accrued liabilities, including the accrued pension benefits, are the most significant items where estimates are used.

Financial Instruments

Financial instruments are measured at fair value on initial recognition. Subsequent to initial recognition they are accounted for based on their classification. Cash and cash equivalents as well as investments are designated as held-for-trading and are measured at fair value. Accounts receivable net of allowance for doubtful accounts are designated as loans and receivables and are carried at amortized cost. Accounts payable and accrued liabilities are classified as other financial liabilities and carried at amortized cost. Because of the short-term nature of the accounts receivable as well as the accounts payable and accrued liabilities, amortized cost approximates fair value.

CIHI has chosen to apply CICA 3861, *Financial Instruments—Disclosure and Presentation*, in place of CICA 3862, *Financial Instruments—Disclosures*, and CICA 3863, *Financial Instruments—Presentation*.

It is management's opinion that CIHI is not exposed to significant interest rate or credit risks arising from the financial instruments.

a) Interest Rate Risk

Interest rate risk refers to the adverse consequences of interest rate changes on CIHI's cash flows, financial position and investment income.

b) Credit Risk

Credit risk relates to the potential that one party to a financial instrument will fail to discharge an obligation and cause the other party to incur a financial loss.

Credit risk concentration exists where a significant portion of the portfolio is invested in securities which have similar characteristics or similar variations relating to economic, political or other conditions. CIHI monitors the financial health of its investments on an ongoing basis.

Capital Management

CIHI's objective when managing capital is to safeguard its ability to continue as an independant not-for-profit organization in an effort to carry out its mandate. Through various contribution agreements, the federal, provincial and territorial ministries of health provide most of CIHI's capital resources. The Investments—Roadmap, restricted by the Health Information Initiative agreement with the federal Ministry of Health, is another source of capital. CIHI manages its related programs and projects within the terms and conditions of these agreements, including the requirement to fund its retirement benefits plans in accordance with related regulations. CIHI's management monitors its capital by reviewing periodically various financial metrics, including cash flow and variances to budget and multi-year forecasts. CIHI has complied with all of its externally imposed restrictions.

In addition, as disclosed in note 9, CIHI has an available line of credit that is used when sufficient cash flow is not available from operations to cover operating and capital expenditures.

3. Cash and Cash Equivalents

Cash and cash equivalents are comprised of cash and short-term investments with a variety of interest rates and having original maturity dates of less than 90 days (2009—90 days).

4. Accounts Receivable

	2010	2009
	$	$
Operating	1,038,596	1,693,231
Funding—other	476,944	1,260,362
	1,515,540	2,953,593

5. Investments—Roadmap

The investments consist of pooled funds, which include low-risk financial instruments, such as GICs, treasury bills and commercial papers.

6. Capital Assets

	2010		2009	
	Cost	Accumulated Amortization	Cost	Accumulated Amortization
	$	$	$	$
Computers	18,463,358	10,101,852	16,044,107	7,857,113
Furniture and equipment	6,833,163	3,374,665	6,750,308	2,806,284
Telecommunication equipment	1,640,645	931,756	1,647,225	666,508
Leasehold improvements	10,597,909	2,626,255	10,392,350	1,536,475
	37,535,075	17,034,528	34,833,990	12,866,380
Accumulated amortization	(17,034,528)		(12,866,380)	
Net book value	20,500,547		21,967,610	

7. Other Assets

Other assets consist of rent deposits to landlords for office space as well as prepaid software, equipment support and maintenance expenses.

8. Accrued Pension Benefits

CIHI has a contributory defined benefit plan (registered retirement plan) which offers its employees annual retirement income based on length of service and final average earnings. In addition, CIHI supplements this benefit to plan members who are affected by the application of the *Income Tax Act*'s maximum pension limit (supplementary retirement plan).

The most recent actuarial valuation for funding purposes of the registered retirement plan was prepared by Mercer, a firm of consulting actuaries, as of January 1, 2009. The next valuation will be as of January 1, 2010.

The fair value of the plans' assets and accrued benefit obligations for accounting purposes were determined by Mercer as at March 31 of each year.

The following tables present the plans' funded status and amounts recognized in CIHI's balance sheet.

The pension plans' expenses include the following components:

	2010		2009	
	Registered Retirement Plan $	Supplementary Retirement Plan $	Registered Retirement Plan $	Supplementary Retirement Plan $
Current service cost, net of employee contributions	1,333,200	30,000	4,093,300	49,900
Interest cost on accrued benefit obligation	1,963,500	24,700	1,886,400	23,800
Expected return on plan assets	(1,985,800)	—	(1,864,700)	—
Amortization of transitional asset	(57,700)	—	(57,700)	—
Amortization of net actuarial gain	(429,300)	(18,000)	—	(6,000)
Pension plan expense	823,900	36,700	4,057,300	67,700

The transitional asset was $923,357 as at April 1, 2000.

Changes in the accrued benefit obligation are as follows:

	2010		2009	
	Registered Retirement Plan $	Supplementary Retirement Plan $	Registered Retirement Plan $	Supplementary Retirement Plan $
Accrued benefit obligation, beginning of year	20,395,400	275,000	27,345,600	359,200
Current service cost, net of employee contributions	1,333,200	30,000	4,093,300	49,900
Interest cost on accrued benefit obligation	1,963,500	24,700	1,886,400	23,800
Employee contributions	2,327,000	—	2,119,300	—
Benefits paid	(1,539,500)	(89,400)	(538,400)	(8,300)
Actuarial loss (gain)	16,741,700	114,400	(14,510,800)	(149,600)
Accrued benefit obligation, end of year	41,221,300	354,700	20,395,400	275,000

	2010		2009	
	Registered Retirement Plan $	Supplementary Retirement Plan $	Registered Retirement Plan $	Supplementary Retirement Plan $
Fair value of assets, beginning of year	27,583,100	—	25,425,681	—
Actual return on assets	6,196,200	—	(5,203,181)	—
Employer contributions	6,586,500	89,400	5,779,700	8,300
Employee contributions	2,327,000	—	2,119,300	—
Benefits paid	(1,539,500)	(89,400)	(538,400)	(8,300)
Fair value of assets, end of year	41,153,300	—	27,583,100	—

The plans' assets consist of

	2010		2009	
	Registered Retirement Plan %	Supplementary Retirement Plan %	Registered Retirement Plan %	Supplementary Retirement Plan %
Asset category:				
Bonds	35	—	35	—
Equities	65	—	65	—
	100	—	100	—

CIHI recorded the assets and liabilities as follows:

	2010		2009	
	Registered Retirement Plan $	Supplementary Retirement Plan $	Registered Retirement Plan $	Supplementary Retirement Plan $
Accrued benefit obligation, end of year	(41,221,300)	(354,700)	(20,395,400)	(275,000)
Fair value of assets, end of year	41,153,300	—	27,583,100	—
Funded status—surplus (deficit), end of year	(68,000)	(354,700)	7,187,700	(275,000)
Unamortized transitional asset	(346,300)	—	(404,000)	—
Unamortized net actuarial loss (gain)	4,260,800	(144,000)	(8,699,800)	(276,400)
Accrued pension benefit asset (liability)	3,846,500	(498,700)	(1,916,100)	(551,400)

The actuarial assumptions, which represent management's best estimate assumptions used to determine costs and benefit obligations, were as follows:

	2010		2009	
	Registered Retirement Plan %	Supplementary Retirement Plan %	Registered Retirement Plan %	Supplementary Retirement Plan %
Service cost for years ended March 31:				
Discount rate	9.00	9.00	6.25	6.25
Expected long-term rate of return on assets	6.75	—	6.75	—
Rate of compensation increase	4.00	4.00	4.50	4.50
Accrued benefit obligation as of March 31:				
Discount rate	6.50	6.50	9.00	9.00
Rate of compensation increase	4.00	4.00	4.00	4.00

9. Bank Indebtedness

CIHI has a line of credit of $500,000 with a financial institution bearing interest at prime rate. This credit facility is secured by a general security agreement on all assets, with the exception of information systems. As at March 31, 2010, a letter of credit of $240,600 (March 31, 2009—$230,600) for the purpose of the supplementary retirement plan had been issued against the line of credit.

10. Accounts Payable and Accrued Liabilities

Accounts payable and accrued liabilities are operational in nature and include, in particular, an amount of $2,530,082 (2009—$31,422) representing the annual excess contribution received from Health Canada for the Health Information Initiative.

11. Deferred Contributions

Expenses of Future Periods

Since 1999, Health Canada has been significantly funding, through the Roadmap Initiative, the building of a comprehensive national health information system and infrastructure to provide Canadians with the information they need to maintain and improve Canada's health system and the population's health. Health Canada's funding contributions were received in the form of global direct payments. The ongoing funding of the Roadmap Initiative along with other funding contributions from Health Canada was consolidated through the Health Information Initiative as of April 1, 2007. Health Canada's funding contribution is received annually based on CIHI's capital resources requirements.

Deferred contributions related to expenses of future periods represent unspent restricted contributions. The changes for the year in the deferred contributions—expenses of future periods are as follows:

	2010 $	2009 $
Balance, beginning of year	**21,300,252**	38,264,909
Current-year contribution received from Health Canada	**81,745,999**	81,746,294
Contribution repayable to Health Canada	**(2,530,082)**	(31,422)
Restricted investment revenue	**15,719**	738,367
Amount recognized as funding—CIHI operations	**(76,129,818)**	(71,912,703)
Amount recognized as funding—CPHI	**(1,409,078)**	(3,415,473)
Amount recognized as funding—Statistics Canada	**—**	(9,219,832)
Amount transferred to deferred contributions—capital assets	**(2,599,762)**	(14,869,888)
Balance, end of year	**20,393,230**	**21,300,252**

Capital Assets

Deferred contributions related to capital assets include the unamortized portions of restricted contributions with which capital assets were purchased.

The changes for the year in the deferred contributions—capital assets balance are as follows:

	2010	2009
	$	$
Balance, beginning of year	**18,435,767**	6,556,939
Amount received from Health Information Initiative contribution	**2,599,762**	13,590,203
Amount transferred from deferred contributions—Roadmap	**—**	1,279,685
Amount recognized as funding	**(3,860,979)**	(2,991,060)
Balance, end of year	**17,174,550**	18,435,767

12. Lease Inducements

The lease inducements include the following amounts:

	2010	2009
	$	$
Leasehold improvement allowances	**1,210,864**	1,445,090
Free rent and other inducements	**1,909,398**	2,155,082
	3,120,262	**3,600,172**

During the year, no free rent or other inducements were received (2009—$1,961,784). The amortization of leasehold improvement allowances and free rent and other inducements are $234,226 and $245,684, respectively (2009—$290,773 and $183,874, respectively).

13. Core Plan

The Core Plan revenue relates to a set of health information products and services offered to Canadian health care facilities, regional health authorities and provincial/territorial ministries of health. Provincial/territorial governments have secured CIHI Core Plan on behalf of all facilities in their jurisdiction.

14. Funding—Other

	2010	2009
	$	$
Provincial/territorial governments	1,362,068	1,353,391
Federal government	2,008,545	2,073,582
Other	4,775	512,396
	3,375,388	3,939,369

15. Net Change in Non-Cash Working Capital Items

	2010	2009
	$	$
Accounts receivable	1,438,053	4,654,062
Prepaid expenses	(342,321)	(516,068)
Accounts payable and accrued liabilities	316,705	1,282,250
Unearned revenue	3,228,183	(197,292)
	4,640,620	5,222,952

16. Related Party Transactions

The CPHI Council is a sub-committee of the CIHI Board of Directors and is composed of leading research and policy experts in population health. As part of the CPHI Council's mandate, the Council reviewed research project applications and recommended funding for research projects. For some research projects, members of the CPHI Council and the CIHI Board of Directors are either directly or indirectly related to the research project applicants or recipient agencies. Both the CPHI Council and the CIHI Board of Directors have adopted a conflict of interest policy governing such situations. These transactions are in the normal course of operations and are measured at the exchange amount, which is the amount of consideration established and agreed to by the related research project applicants or recipient agencies.

Research project expenses for which the research project applicants or recipient agencies were related to the members of the CPHI Council or the CIHI Board of Directors represent $435,482 (2009—$380,220). At the end of the year, the amounts due to these research project applicants or recipient agencies were $119,105 (2009—$134,464).

17. Commitments

CIHI leases office space under different operating leases, which expire on various dates. In addition, CIHI is committed under various agreements with respect to research contributions, professional contracts and software and equipment maintenance and support. The minimum amounts payable over the next five years and thereafter are as follows:

	$
2011	12,840,314
2012	9,497,893
2013	8,745,012
2014	8,741,596
2015 and thereafter	26,550,849

18. Comparative Financial Statements

The comparative financial statements have been reclassified from statements previously presented to conform to the presentation of the current year's financial statements.

Production of this report is made possible by financial contributions from Health Canada and provincial and territorial governments. The views expressed herein do not necessarily represent the views of Health Canada or any provincial or territorial government.

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